

Case Number:	CM14-0036190		
Date Assigned:	06/25/2014	Date of Injury:	10/16/2008
Decision Date:	07/28/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	03/24/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 50-year-old male who had work related injury on 10/16/08. He stated that he slipped on a wet floor while cleaning a toilet. His body twisted, he fell landing on his tailbone jerking his neck and back and then struck his head on a nearby wall. The injured worker experienced immediate low back pain and neck pain and developed a headache. The injured worker was seen at a [REDACTED], examined then provided with analgesic and anti-inflammatory medications. The injured worker continued working at his regular duties, noting increased pain with bending, twisting, pushing, pulling and lifting of items up to 100 pounds. He was then referred for one session of physical therapy. Magnetic resonance imaging (MRI) of the cervical spine dated 09/30/11, central stenosis of moderate to severe degree at C3-4 and C4-5. There was associated reduction of cord calibre by up to 50%, most focally at C3-4 related to a right paracentral disc protrusion. There were signal changes within the cord at C4-5 consistent with myelomalacia. Multiple levels of neural foraminal stenosis mostly affecting the mid cervical levels of moderate degree. MRI of lumbar spine dated 08/16/13 at L3-4 there was 1-2mm diffuse disc bulge but the spinal canal and neural foramen were patent. At L4-5 there was mild height loss with a 2mm diffuse disc bulge rendered mild to moderate spinal canal narrowing. Neural foramen narrowing on the right but patent on the left. Electromyogram/Nerve Conduction Velocity of the lumbar spine and bilateral lower extremities dated 10/08/13 no electrical evidence of lumbar radiculopathy or plexopathy affecting L3 through S1 lower motor nerve fibers in the left lower extremity or the corresponding lumbar paraspinals. Handwritten note dated 02/12/14 was illegible. Physical examination dated 01/21/14 mild antalgic gait to the left with use of a cane. Heel toe walk performed without difficulty on the right and unable to perform on the left. Diffuse tenderness over the paravertebral musculature. There was moderate facet tenderness over the L4-5 and L5-S1

spinous processes. Negative piriformis tenderness, negative piriformis stress test. Sacroiliac joint tenderness negative on the right positive on the left. Patrick test was negative on the right, positive on the left. Sacroiliac joint thrust test positive on the left, negative on the right. Yeoman test was positive on the left and negative on the right. Referred back pain with straight leg raise at 60 degrees in the seated position and 50 degrees in the supine position. Lumbar range of motion flexion to 50 degrees extension 10 degrees, lateral bending to the right and left 20 degrees. Sensation was intact to pain, temperature, light touch, vibration, and two-point discrimination in all dermatomes. Strength in lower extremities rated 5/5 to manual motor testing. Reflexes were 2+ in lower extremities. Diagnosis was lumbar disc disease. Lumbar facet syndrome. Left sacroiliac joint arthropathy. He failed conservative treatment, including physical therapy, chiropractic services, medication, rest, and home exercise program. The injured worker was referred for sacroiliac joint injection. The injured worker had a left sacroiliac joint injection on 02/19/14 the injured worker reported 85% improvement after the procedure. Request for left sacroiliac joint rhizotomy prior utilization review on 03/21/14 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Left Sacroiliac Joint Rhizotomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and pelvis chapter, Sacroiliac joint radiofrequency neurotomy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pelvis and hip chapter, Sacroiliac joint radiofrequency neurotomy.

Decision rationale: The request for left sacroiliac joint rhizotomy is not medically necessary. The current evidence: based guidelines do not support the request. Not recommended. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Therefore, medical necessity has not been established. The request is not medically necessary and appropriate.